

**Patients Information Sheet**  
**Please Print**

Referring Doctors name: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: M F Martial Status: M D S W Separated

Last Menstrual Period: \_\_\_\_\_

Patients Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employers Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Phone #: \_\_\_\_\_

Patients Social Security Number: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Spouses Date of Birth: \_\_\_\_\_

Spouses Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Spouses Social Security Number: \_\_\_\_\_

Subscribers Name: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Persons name to notify in Case of an Emergency: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_

**I hereby authorize Providence Hospital to furnish the requested diagnostic services and/or Medical treatment.**

Signature: \_\_\_\_\_

**PROVIDENCE HOSPITAL & MEDICAL CENTERS - MEDICAL PRACTICE NETWORK  
PATIENT INTAKE HISTORY**

Date of Visit: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Referred By: \_\_\_\_\_  New Patient  Established Patient

Telephone: Home: \_\_\_\_\_ Pager: \_\_\_\_\_

Work \_\_\_\_\_ Ext. \_\_\_\_\_

Cell \_\_\_\_\_

Reason for the visit: \_\_\_\_\_

Medications (include all meds & herbs): \_\_\_\_\_

**LABS**

Last pap smear / / Last mammogram / / Last colonoscopy/sigmoidoscopy / /

Last test for blood / / Previous ultrasound of pelvis or CT scans / /

**GYNECOLOGY HISTORY**

Last menstrual period / / Length of cycle: \_\_\_\_\_  
(beginning of the period to the beginning of the next period)

Age at onset of period: \_\_\_\_\_

Number of days of flow:  Normal  Heavy  Light

If heavy, how many days: \_\_\_\_\_ How many pads/tampons per day: \_\_\_\_\_

Painful periods:  No  Yes How many days: \_\_\_\_\_

Changes in the menstrual  No  Yes Describe: \_\_\_\_\_  
Periods in the past one year

PMS symptoms:  No  Yes Describe the duration and symptoms: \_\_\_\_\_

Menopause:  No  Yes The year of menopause: \_\_\_\_\_

Menopausal symptoms:  No  Yes Describe: \_\_\_\_\_

Pelvic pain:  No  Yes Describe: \_\_\_\_\_

Vaginal discharge or itching:  No  Yes Describe: \_\_\_\_\_

Sexually active:  No  Yes Libido:  Normal  Decreased

Number of lifetime sexual partners:  Heterosexual  Homosexual Sexually transmitted diseases:  No  Yes  
 Chlamydia  Gonorrhea  Venereal Warts  Herpes  Other

Pain with intercourse:  No  Yes  Positional  Deep  At the entrance

Contraception:  No  Yes Type of contraception: \_\_\_\_\_

Sterilization procedure:  No  Yes  Tubal ligation  Vasectomy

Self breast examination  No  Yes  Monthly  Sporadic

**OB HISTORY**

No. of pregnancies: \_\_\_\_\_ No. of deliveries: \_\_\_\_\_  Premature  Term  Abortions: \_\_\_\_\_

No. of vaginal deliveries: \_\_\_\_\_ No. of C-sections: \_\_\_\_\_ Labor & delivery complications:  Yes  No

If yes, explain: \_\_\_\_\_

Name:

Date:

### PAST MEDICAL HISTORY

None  No change since last visit

Asthma  Cancer  High Blood Pressure  Heart disease  Angina

Pneumonia  Stomach problems  Gallbladder disease  Bowel problems  Anemia & Blood disorders

Autoimmune diseases (like Lupus)  Kidney and Bladder problems  Hepatitis & Jaundice  Deep vein phlebitis  Birth defects or inherited diseases

Neurological disease and seizure disorder  Blood transfusions  Sexually transmitted diseases  Thyroid problems  Musculo-Skeletal or back pain

Diabetes  Headache  Arthritis  Other problems:

Physician Notes:

List hospitalizations for serious medical illnesses or injuries:

### PAST SURGICAL HISTORY

None  Hysterectomy  No  Yes Date / /  Ovaries removed  No  Yes Date / /

Bladder suspension  No  Yes Date / /

List other surgeries and dates:

### FAMILY HISTORY

(include parents, grandparents, brothers, sisters, aunts, uncles and children)

Non contributory  No interval change since / /

Mother  Living  Deceased-cause: Age: Father  Living  Deceased-cause: Age:

Your siblings: Number living Number deceased Causes:

Your children: Number living Number deceased Causes:

Diabetes  Heart disease  High Blood Pressure  Increased Cholesterol  Breast Cancer  Ovarian Cancer

Uterine Cancer  Colon Cancer  Other Cancers  Blood clots in the legs and lungs  Stroke  Other

### SOCIAL HISTORY

Smoking:  No  Yes  Past user Packs per day: No. of years:

Alcohol:  No  Yes No. of drinks per day: No. of drinks per week:

Drug Usage:  No  Yes Names of drugs:

Seat belt usage:  No  Yes

Domestic Violence:  No  Yes  Past (physical or verbal abuse)

Sexual Abuse:  No  Yes  Past

Married  Single  Widowed  Divorced  Separated

No. of people in household:

Name:

Date:

**IMMUNIZATIONS**

Tetanus & Diptheria / / Hepatitis B / / Influenza vaccine / /

Pneumonia vaccine / / Measles, mumps & rubella / / TB skin test / /

**REVIEW OF SYSTEMS**

Constitutional  Negative  Weight loss  Weight gain

Eyes  Negative  Vision changes  Glasses/contacts

Ear Nose & Throat  Negative  Hearing Loss  Sinus problems  Sinus headaches

Cardiovascular  Negative  Chest pain  Difficulty breathing  Edema  Palpitations or irregular heartbeat

Respiratory  Negative  Wheezing  Shortness of breath  Chronic cough  Blood in the sputum

Gastrointestinal  Negative  Diarrhea  Bloody stool  Constipation  Nausea & Vomiting  Bleeding

Urinary  Negative  Urgency  Frequency  Involuntary loss of urine

Loss of urine with coughing/sneezing  Blood in the urine/pain

Incomplete emptying  Dysurea

Musculoskeletal  Negative  Muscle or joint pain Site of pain: \_\_\_\_\_

Degree of pain: 1-10 (10=worst)

Breast  Negative  Pain  Discharge  Lumps

Skin  Negative  Rashes  Ulcers  Moles  Dry skin

Neurologic  Negative  Syncope  Seizures  Numbness

Trouble walking  Dizziness  Headaches  Severe memory problems

Psychiatric  Negative  Depression  Crying  Severe anxiety  Other

Endocrine  Negative  Diabetes  Hypothyroid  Hyperthyroid

Heat or cold intolerance  Hot flashes  Hair loss

Hematologic and Lymphatic  Negative  Bruises  Bleeding  Enlarged lymph nodes

Pain  Negative Site of pain \_\_\_\_\_

Degree of pain 1-10 (10=worst)

**Physician notes:**